

CARRIER'S RESPONSE
Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

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|--|-------|---------------|---|---------------|----------|----------|--|
| Social Security Number | | Date of Birth | | Employee Name | | | |
| Employee Address (Street No. and Name) | | | Employee City | | State | Zip Code | |
| Date(s) of Injury | | | Insurance Company/TPA Claim Number | | | | |
| Employer | | | Insurance Company or TPA (If self-insured) | | | | |
| Employer Address (Street No. and Name) | | | Insurance Company Address (Street No. and Name) | | | | |
| City | State | Zip Code | City | State | Zip Code | | |
| Federal ID Number | | | NAIC or Self-Insurance Number | | | | |
| <div style="display: flex; justify-content: space-between;"> 1. Do you dispute that the injury or disability is work related? Yes No </div> <div style="display: flex; justify-content: space-between;"> 2. Do you dispute that the claimant is disabled? Yes No </div> <div style="margin-top: 10px;"> 3. List reasons supporting your position in the space provided. </div> | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 4. Have you had the claimant medically examined in connection with this claim? Yes No </div> <div style="margin-top: 5px;"> If yes, give name and address of individual who performed the examination. </div> | | | | | | | |
| 5. Do you certify that to the best of your knowledge all existing medical records of the carrier or employer contained in your file that are relevant to this claim have been furnished to the claimant and/or the claimant's attorney? <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Yes No </div> | | | | | | | |
| Claims person/attorney to whom correspondence should be sent | | | Attorney ID Number (If applicable) | | | | |
| Claims office/attorney address | | | Telephone No. (Include area code) | | | | |
| Preparer Signature | | | | | | Date | |

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| The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency. | <div style="display: flex;"> <div style="width: 20%; font-weight: bold;">Authority:</div> <div>Workers' Disability Compensation Act, Section 418.222</div> </div> <div style="display: flex;"> <div style="width: 20%; font-weight: bold;">Completion:</div> <div>This form is to be submitted by the carrier within thirty (30) days after the carrier's receipt of a completed Application for Mediation or Hearing.</div> </div> <div style="display: flex;"> <div style="width: 20%; font-weight: bold;">Penalty:</div> <div>Failure to complete shall prohibit that party from proceeding.</div> </div> |
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